STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007306	A. BUILDING: _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: #2324621/IL160587	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide supervision to a resident with severely impaired cognition and a history of falls, failed to implement fall interventions, and failed to document a thorough investigation of a fall for one of three residents (R1) reviewed for falls in the sample of three. These failures resulted in R1 falling, hitting his head, and sustaining a Subarachnoid hemorrhage (brain bleed) on 5/3/23. Findings include: The facility's Resident Accident/Incident policy dated 8/27/21, states "Those individuals identified at risk for falls, will be identified for staff to monitor more closely. On a daily basis incidents/accidents will be investigated and	S9999		

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S9999	Continued From page 2 reviewed by the facility administrative staff. Necessary intervention changes will be made in the resident's care plan." The facility's Fall Policy and Procedure dated 1/2/19 states, "The nurse will complete the necessary documentation: A. Enter a complete description of the incident including, who was notified, any orders received, vital signs, description of any injury, any treatment administered, witnesses, and/or transportation to (Emergency Room) information." R1's electronic medical record documents R1 was admitted to the facility on 1/28/23 with diagnoses which included, Cerebral Infarction with right sided hemiparesis, Alcohol Induced Dementia, and Anxiety Disorder. R1's Minimum Data Set assessment dated 5/16/23, documents R1 had severely impaired cognition and was unable to ambulate independently. R1's electronic Physician Orders dated 5/2023, document R1 was taking Eliquis (blood thinner) 5 mg (milligram) daily. R1's Fall Evaluations dated 2/3/23, 2/17/23, and 5/16/23, document R1 was at risk for falls. R1's Care Plan dated 2/14/23, states "(R1) is at risk for falls due to weakness, poor balance, and confusion. (R1) has had falls prior to his admission." R1's Fall Investigation dated 2/24/23 at 2:05 p.m., documents R1 had an unwitnessed fall in his room trying to get out of bed without assistance. R1 did not sustain any injuries. This same	S9999		

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S9999	Continued From page 3 Investigation documents "Recommended steps to prevent recurrence: Make sure (R1) is not in the (wheelchair) in his room unsupervised and remove wheelchair from room when he is in bed." R1's Fall Investigation dated 4/25/23 at 4:23 p.m., documents R1 was observed standing up from his wheelchair and slid down to the floor. R1 did not sustain any injuries. This same Investigation states "Recommended steps to prevent recurrence: Monitor (R1) and remind to not get up when seen trying to get up." R1's Fall Investigation dated 5/3/23 at 10:50 p.m., documents R1 had an unwitnessed fall in his room. R1 hit his head on the floor causing a quarter sized laceration to right eye area and a bruise to his left lower back area. R1 was sent to the local hospital and was admitted with a diagnosis of Subarachnoid Hemorrhage. R1's Hospital CT (Computed Tomography) of the head or brain report dated 5/4/23, documents R1 sustained a post traumatic acute Subarachnoid Hemorrhage in the left frontal lobe. On 6/8/23 at 10:21 a.m., V10 (Registered Nurse) stated "I took care of (R1) on 5/3/23 and one of the (Certified Nurse Aides) had put (R1) to bed not too long before I found him on the floor. He was on the floor closer to the bathroom. I can't remember exactly where his wheelchair was, but it was in his room. I can't say whether he had tried to get in the wheelchair at any point since he is confused and could not tell me what happened. I think he was trying to use the restroom alone due to his diagnosis of Dementia. He can't ambulate alone very far, if at all, without falling. He has a habit of trying to continually get up without assistance. We (the facility) don't use fall	S9999		

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S9999	Continued From page 4 alarms anymore, so I know he didn't have one. I had a Certified Nurse Aide in the room with me, but I cannot remember who it was. I should have had her document a statement of what she observed after the fall." On 6/9/23 at 3:00 p.m., V2 (Director of Nursing) stated R1's fall interventions did include to not leave his wheelchair in his room. V2 stated after his first fall that intervention was implemented hoping he would not visualize the wheelchair and try to get out of bed alone. V2 stated R1 had a habit of trying to stand/get up without assistance. V2 stated R1's wheelchair should not have been in his room on 5/3/23 once he was put to bed. V2 stated V10 should have had the Certified Nurse Aide that assisted her write a statement, so we know who else was involved after the fall. V2 stated he was unable to determine who the Certified Nurse Aide was that assisted V10 after R1 was found on the floor on 5/3/23. (A)	S9999		